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Dear Applicant:

Enclosed you will find application materials for the State Medical Education Board (SMEB) *Georgia Physician Loan Repayment Program* (GPLRP) which became effective July 1, 1989. The enclosed Applicant Information Bulletin gives a description of the program for the period of July 1, 2006, through June 30, 2007.

The purpose of this program is to grant service cancelable loans of up to $25,000.00 each year to physicians to repay their outstanding medical education debt on the condition that the physician practice in an under-served rural area in Georgia. A participant in the program must practice for a minimum of 2 years in a targeted rural area. A participant may elect to re-apply for an additional funding awarded on an annual basis for 2 years for a maximum of 4 years funding with approval of the State Medical Education Board. The targeted underserved rural areas under this program are reviewed in the spring of each year and are subject to change.

The State Medical Education Board places priority on certain specialties in determining grant awards. These priorities are established through review of data on the state physician workforce and the availability of eligible specialties throughout the state.

Physicians who have defaulted on federal loans/scholarships or who have any other outstanding service obligation cannot be considered for funding through this program until the obligations(s) have been satisfied. **Application to this program does not guarantee Board approval or funding.**

Complete the enclosed Provider Application and return it by November 1, 2006. Forward the County Application to the appropriate officials from the community in which you plan to practice. County officials should then complete and return the County Application by November 1, 2006. Your application will not be considered complete until both applications have been received. Applications will be presented to the State Medical Education Board Members in December. Feel free to contact me at 404/206-5420 or SMEB@dch.ga.gov.

Sincerely,

Ben Robinson
Executive Director

Enclosures

1718 Peachtree Street, NW, Suite 683, Atlanta, Georgia 30309-2496 • Telephone 404-206-5420 • Fax 404-206-5428

State Medical Education Board of Georgia

Georgia Physician Loan Repayment Program

Applicant Information Bulletin

Funding for this program is contingent upon notice of grant award from the Federal Government

This Bulletin describes the Georgia Physician Loan Repayment Program (GPLRP). Participants will be bound by contract to adhere to the provisions described in this document. Other conditions also apply, referenced in contract, and pertain to State Medical Education Board Statute, Rules and Regulations, and Federal Regulations

Please keep this Bulletin for future reference. It explains in detail the obligations of program participants.

PURPOSE OF THE PROGRAM

- To build viable practices in Georgia's medically underserved areas
- Encourage economic growth in Primary Medical Care Health Professional Shortage Areas
- Improve healthcare delivery by increasing access to health care and minimizing disparities for rural Georgians

The Georgia Physician Loan Repayment Program (GPLRP) is a program designed to repay outstanding medical education loan debt of physicians willing to practice in eligible rural Georgia counties. To be eligible, counties must have populations of 35,000 or fewer persons according to the most recent United States Census Count and be designated as a Primary Medical Care Health Professional Shortage Area (HPSA) by the federal government.

While the HPSA designation is an important qualifier for this program, the State Medical Education Board does not approve practice sites solely upon a HPSA designation. Criteria for selection also include the Georgia Loan Repayment priority targeting of Georgia counties.

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

Funds provided through this program are to be used for the repayment of existing medical education loan debt. The State Medical Education Board (SMEB) has set the maximum award amount for the Georgia Physician Loan Repayment Program at up to $25,000.00 per year for physicians. All awarded funds are expended toward repayment of a participant's qualified medical education loans. Qualified medical education loans include the principal and interest related to a government or commercial medical education loan. To be considered for an award, applicants must document all outstanding medical education loan debt.

Georgia Physician Loan Repayment Program participants must practice their profession for a period of at least two years (two year minimum, two renewals of one year each, four year maximum) at a site approved by the SMEB and in compliance with federal Loan Repayment Program requirements. Approved sites must be in a federally recognized Primary Medical Care Health Professional Shortage Area that is also in a Georgia county with 35,000 or fewer residents. The practice sites must also be a public or nonprofit facility. Public facilities would include facilities owned and operated by the Georgia Department of Human Resources, Georgia Department of Corrections or Georgia Department of Juvenile Justice.

Physicians must practice their specialty full-time (a minimum of 40 clinical hours per week) in the practice entity named in the physician application. "Full-time clinical practice" is defined as a minimum of 40 hours per week of patient care at an approved service site, with no more than 8 of those hours per week devoted to practice-related administrative activities. The practice will include hospital treatment coverage appropriate to meet the needs of the patients of the approved site and to ensure continuity of care. Research and teaching are not considered to be "clinical practice" and time spent "on-call" is not considered part of full-time practice. An exception to these rules is allowed for providers of obstetrical care.

For providers of obstetrical care, the majority of full-time service (not less than 21 hours per week) is to be devoted to direct patient care in an approved ambulatory care practice site during normal scheduled office hours. The remaining hours can be spent providing inpatient care to patients of the approved site and/or on practice related administrative duties. Time spent on administrative duties cannot exceed 8 hours per week. Time spent "on-call" is not considered part of full-time practice.

For all health professionals, no more than 7 weeks (35 days) per year can be spent away from the practice for vacation, holidays, continuing professional education, illness, or any other reason. Absences greater than 7 weeks in a GPLRP service year will extend the service commitment end date.

The funds that the physician may receive from this program are in addition to any other salary, benefits or other compensation the physician receives as part of a practice and/or employment arrangement provided there is no duplication of benefits.

Other criteria for approval include:

- Physicians must maintain a Medicare and Medicaid number and actively see Medicaid, Medicare and PeachCare patients
- Physicians must live in the community they are approved to serve
- Physicians cannot be obligated or have defaulted on any previous service commitment to the Federal government or State of Georgia

APPLICANT ELIGIBILITY

Eligible Applicants must:

- Be licensed to practice medicine within the State of Georgia at the time the application is made;
- Be a graduate of an accredited four-year medical school located in the United States which has received accreditation or provisional accreditation by the Liaison Committee on Medical Education of the American Medical Association or the Bureau of Professional Education of the American Osteopathic Association, for a program of education designed to qualify the graduate for licensure by the Composite State Board of Medical Examiners of Georgia;
- Have completed or be in their final year of an approved graduate training program in allopathic or osteopathic medicine in the United States; and
- Practice medicine in an approved specialty, which include: Family Medicine (and Osteopathic general Practice), General Internal Medicine, General Pediatrics, Obstetrics/Gynecology, and General Psychiatry**.**

ELIGIBLE STUDENT LOANS

Student loans incurred for tuition, fees, and other expenses associated with completion of a medical degree are eligible for payment under the Georgia Physician Loan Repayment Program.

Student loan debt incurred to complete other academic degrees is not eligible for payment under the Georgia Physician Loan Repayment Program

PRIORITY OF APPLICANTS

The State Medical Education Board places priority on certain specialties in determining grant awards. These priorities are established through review of data on the state physician workforce and the availability of eligible specialties throughout the state. **The priority listing is subject to change, and applicants are encouraged to contact the SMEB office for the current priority list. The current order of priorities is as follows**:

1) Obstetrics/Gynecology
2) Family Medicine/Obstetrics
3) Family Medicine
4) General Internal Medicine
5) General Pediatrics
6) General Psychiatry

APPLICATION REQUIREMENTS

All Eligible Applicants must:

- Be a citizen of the United States of America;
- Submit an application to participate in the Georgia Loan Repayment Program (Submitting an application does not guarantee selection);
- Disclose all outstanding medical educational loan debt. Applicants must provide a copy of all qualifying loan documentation (e.g., promissory notes). If an applicant has consolidated loans or refinanced loans, the applicant must provide a copy of the original loan documentation to establish the education purpose and contemporaneous nature of such loans. If an eligible education loan is consolidated/refinanced with any other debt other than another eligible education loan of the applicant, no portion of the consolidated/refinanced loan will be eligible for loan repayment;
- Attest that the applicant does not have other current service obligations to the Federal Government (e.g., National Health Service Corps, Military Service Obligations) or a State or other entity, prior to the beginning of this contract;
- Have submitted all documents for a complete application by **November 1st**;
- Sign and submit with the application a brief needs assessment about the proposed practice site including length of service commitment to community and date of availability;
- Submit copy of employment contract;
- Satisfy all requirements for unrestricted medical licensure by the Composite State Board of Medical Examiners of Georgia;
- Contractually agree to practice full-time (minimum of 40 clinical hours per week) in a public or nonprofit practice entity, which serves patients regardless of their ability to pay and make use of a sliding fee scale for payment of services;
- Establish residence in the community named in application;
- Accept Medicare, Medicaid and PeachCare patients, as appropriate;
- Monitor and ensure that a Georgia Physician Loan Repayment Program County Application has been completed and forwarded to the State Medical Education Board administrative office;
- Submit typed letters from three personal references who can attest to the applicant's commitment to live and practice in a rural setting, including their candid opinions concerning the applicant's success in reaching this goal;
- Submit typed letters from three professional references who can attest to the applicant's clinical abilities and commitment to practice in a rural setting, including their candid opinions concerning the applicant's ability to contribute effectively to health care in rural Georgia.

NOTE: State Medical Education Board Scholarship recipients or Georgia Higher Education Assistance Corporation Osteopathic Student Loan recipients are not eligible to apply for this funding.

CANCELLATION PROVISION

The only permissible basis for canceling a Georgia Physician Loan Repayment Program contract is the death of the GPLRP participant.

WAIVER PROVISION

A participant may request a waiver of the GPLRP obligation. A waiver is a permanent status. The basis for a waiver would be a medical condition or a personal situation that: 1) results in the individual's permanent inability to serve the obligation or pay the debt; or 2) would involve a permanent extreme hardship to the individual and would be against equity and good conscience to enforce the service or payment obligation.

SUSPENSION PROVISION

Participants may request a suspension of their GPLRP obligation. A Suspension may be granted, for up to 1 year. The basis for a suspension would be a physical or mental health disability, or terminal illness of an immediate family member, that results in the participant's temporary inability to perform the GPLRP obligation, medical condition or a personal situation that: 1) would make it temporarily impossible for the participant to continue the service obligation or payment of the monetary debt; or 2) would temporarily involve an extreme hardship to the individual and would be against equity and good conscience to enforce the service or payment obligation.

DEFAULT PROVISION

Participants who fail to begin or complete their GPLRP service obligation or otherwise breach the terms and conditions of the obligation are in default of their contracts and are subject to the financial consequences outlined in their contracts and in Federal Regulations.

PENALTY FOR BREACH OF CONTRACT

A participant who breaches GPLRP obligation will be subjected to paying an amount equal to the sum of the following:

a. the total of the amount paid by the GPLRP to, or on behalf of, the participant for loan repayments for any period of obligated service not served; and
b. an amount equal to the number of months of obligated service not completed multiplied by $7,500; and
c. interest on the above amounts at the maximum legal prevailing rate, as determined by the treasurer of the United States, from the date of breach, except that the amount to recover will not be less than $31,000.

SELECTION CRITERIA

Eligible applicants will compete for a position in the program for the current fiscal year based on the following criteria:

- **Specialties Needed by the State Medical Education Board/Georgia Physician Loan Repayment Program**

Priority will be given to those applicants who are specializing in and actively practicing obstetrics. After giving such priority, the Board may also consider, in the following order of priority, the applications of physicians specializing in family practice, general internal medicine, general pediatrics and general psychiatry.

- **Commitment to Professional Practice in Medically Underserved Areas**

Indication of an applicant's degree of commitment to practice as expressed in an essay describing the applicant's desire to live and work in an underserved rural Georgia community.

- **Earliest Availability for Service**

Applicants will be considered based in part on their availability to begin service; preference will be given to applicants readily available to begin service.

- **Home Area of the Applicant**

The Board is authorized to consider, among other criteria for granting loans under the provisions of this program, the residency status and home area of applicant.

- **Professional Qualifications; References Indicating Special Clinical Competence for Rural Practice**

An applicant's professional qualifications and competence to practice in a designated State Medical Education Board target area will be considered. This may include such factors as:

Board eligibility or certification in his/her specialty;

Unusual breadth of clinical skills acquired during applicant's residency that would be of special value in a rural practice, as documented by copies of training records;

Notable professional achievements during training, as documented by residency/clinical supervisors;

Indications of unusual professional competence received from department heads, supervisors, program directors, etc. during residency training, and

References from superiors about applicant's clinical competence during post-residency practice (particularly if in a rural or State Medical Education Board designated target area).

STEPS TO TAKE

Complete Application, Lender Disclosure Form, Authorization and Release Form and Summary Data Sheet and provide a copy of promissory note for educational loans and return to the State Medical Education Board, Georgia Physician Loan Repayment Program. Applicants should mail their completed applications to the State Medical Education Board at 1718 Peachtree Street, NW, Suite 683, Atlanta, Georgia 30309-2496. Please telephone 404/206-5420 for assistance.

Select A target area (county) where you wish to live and practice full-time and complete a brief description of the health care needs of the target area.

Select A public or non-profit facility, located in a Primary Medical Care Health Professional Shortage Area, in a County in Georgia with a population of 35,000 or less in which to practice. Provide a copy of the contract between you and your practice entity.

Review County Application before forwarding to appropriate officials for completion and submission to the State Medical Education Board.

Request Documentation of outstanding educational loan debt from all lenders using Debt Disclosure Form provided with application.

Sign A two-year contract with the Georgia Physician Loan Repayment Program/State Medical Education Board with the possibility of renewal contracts of one year each, for a maximum of four years. The contract provides, among other things, for payments to be made to the
lending institution to repay outstanding medical education loans in return for practice in a target area.

Facts to Remember

Practice entities must be either a public or nonprofit facility and be located within a designated Primary Medical Care Health Professional Shortage Area and in a county of 35,000 or less population and currently targeted for support from the Georgia Physician Loan Repayment Program.

As of January 1, 2004, funds disbursed for the Georgia Physician Loan Repayment Program are tax exempt.

While the State Medical Education Board understands the vested interest of multiple partners in your obtaining financial assistance, they are not obligated in any way to statements of fact not incorporated as a part of this document or other documents prepared by the authority of the State Medical Education Board. Representations as to regulations, the likelihood of funding, amount of funding, manner and time schedule for funding may be unreliable if not obtained from the State Medical Education Board. Program eligibility is solely determined by the State Medical Education Board.

FURTHER INFORMATION AND ASSISTANCE

Please contact the State Medical Education Board of Georgia if you have any questions or need additional information.

The State Medical Education Board of Georgia
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496
404-206-5420 – Office Phone
404-206-5428 – Fax

Website: www.SMEB.georgia.gov
E-mail: SMEB@dch.ga.gov

revised 6/06

STATE MEDICAL EDUCATION BOARD

Physician Application

GEORGIA PHYSICIAN LOAN REPAYMENT PROGRAM

SECTION I – PERSONAL DATA

Please type or print with ink.

Applicant Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Home Phone: _____

Ethnic Origin: _____ Birth Date: _____

Birth Place: _____ Are you a United States Citizen? ____Yes ____No

Language other than English: _____ _____Speak _____Write _____Read

SECTION II - SPECIALTY

_____ M. D. _____ D. O.

_____ Family Practice ____with OB

_____ General Pediatrics

_____ General Surgery

____ General Internal Medicine

____ Obstetrics/Gynecology

____ Other, Name Specialty:

_____

SECTION III - MEDICAL EDUCATION

Medical School: _____ Graduation Date: _____

City: _____ State: _____ Zip Code: _____

Residency Hospital: _____ Graduation Date: _____

City: _____ State: _____ Zip Code: _____

Board Certified: __ Board Eligible: __ GA License #: _____ Medicaid #: _____

SECTION IV – PRACTICE SITE

Applicant agrees to provide full-time primary care services for one year at:

Practice Site Name: _____

Address: _____

City: _____ County _____ Zip Code: _____

Telephone: _____ Fax: _____

Type of practice: ___Hospital Based ___Group ___Private ___CHC

Beginning Date of Practice: _____ (This is not the date service will commence)

Number of clinical hours per week at this practice location: _____

Include a copy of the contract between yourself and your practice/employer.

SECTION V –MEDICAL EDUCATION DEBT

Estimate of total outstanding medical educational debt from all loan holders: $_____
Request submission of the attached *Lender Disclosure Form* from each loan holder.

Attach a copy of the original promissory note and current loan statement for each loan listed. Loan statements must contain Applicant's name, account number, interest rate, the principle and payoff balance.

1. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

2. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

3. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

4. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

SECTION V – MEDICAL EDUCATION DEBT (continued)

.

5. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

6. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

SECTION VI – PRACTICE SITE ASSESSMENT

On a separate sheet, type an assessment of your practice including the following:

- Percentage of low birth weight babies of total births, infant mortality per 1,000 births, cancer deaths and cardiovascular deaths per 100,000 population, percentage of elderly population and percentage of the population living below 200% of the poverty level.
- Describe the patient population in terms of age, sex, economic status, cultural diversity, language and major health problems.
- Estimate the number of migrant or seasonal workers and describe the provision of health services to this population by your practice.
- Describe any special barriers to the provision of healthcare, such as geography, language or culture.
- State your plan for meeting the particular health care needs of your patients.

SECTION VII - CERTIFICATION

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I hereby consent fully to verification of any and all information included in this application. I understand that any willfully false representation of information is sufficient cause for rejection of this application.

_____ _____

Applicant Signature (Full Legal Name) Date

Official Notary:

I HEREBY CERTIFIY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____(applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of_____, County of _____and

State of_____, this _____day of _____2006.

_____

Notary Public (Full Legal Signature)

Affix Seal My commission expires: _____

Mail your completed application to:

State Medical Education Board of Georgia
Georgia Physician Loan Repayment Program
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496

Direct questions to 404-206-5420 or
E-mail: SMEB@dch.ga.gov
Website: www.SMEB.georgia.gov

Rev.5/06

STATE MEDICAL EDUCATION BOARD

County Application

GEORGIA PHYSICIAN LOAN REPAYMENT PROGRAM

SECTION I – PRACTICE SITE INFORMATION

Please type or print with ink.

Name of Practice Site: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Practice Phone: _____ Practice Ownership: _____

Site Description: _____
(e.g., Hospital Clinic, Community Health Center, 330 Clinic, Rural Health Clinic, County owned Clinic, etc)

Practice Type: _____Public _____Private Non-Profit _____Private For-Profit

Attach Internal Revenue Services non-profit documentation, if applicable

County: _____ Referral Hospital: _____

Hospital Address: _____

City: _____ State: _____ Zip Code: _____

Hospital Ownership:_____

Other towns in practice service area: _____

Name of Provider whose application this County Application supports:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Specialty: _____

SECTION II - PRACTICE SITE ASSURANCES

Practice site Official must initial all requirements with which practice entity intends to comply

1. Salary:

_____ shall compensate providers at salaries that are competitive with other health professionals in the area.

_____ Site shall not use Loan Repayment Program award as a means to reduce provider salaries or offset provider salaries.

2. Accessibility:

_____ Providers will accept assignments for Medicare and Medicaid patients.

_____ Site uses sliding discount fee schedule that assures no financial barriers to care.

_____ Site will conspicuously post a statement of nondiscrimination based on ability to pay.

_____ Site has a nondiscrimination policy that prohibits discrimination based on race creed, disability or religion.

3. Comprehensive System of Care:

_____ Providers shall practice in ambulatory care settings that assure the availability of services, including lab and x-ray, pharmacy, after-hours and referral arrangements for services not available on site.

4. Quality of Care:

_____ Site has credentialing program in place to review references and verify licensure and certification status of all providers.

_____ Site warrants that a review of references and verification of licensure has been conducted concerning providers applying for the Georgia Physician Loan Repayment Program funds referenced in this application.

_____ Site has an improvement system in place that may include patient satisfaction surveys, peer review systems, clinical outcome measures, etc.

_____ Services will be delivered in a culturally appropriate fashion so as to be sensitive and responsive to the needs of the target population.

_____ Site will address retention of providers through clinical team management efforts, salary compatibility surveys, monitoring of turnover, exit interview, etc.

SECTION II – PRACTICE SITE ASSURANCES (continued)

5. Provider Employment Contract:

_____ Provider shall practice only in the approved site targeted by the Georgia Physician Loan Repayment Program and named in the provider application as approved by the State Medical Education Board for a period of two years.

_____ All providers will have contracts or employment agreements that stipulate providers perform full-time clinical practice defined as a minimum of forty hours per week and a minimum of 45 weeks per year.

_____ Contract shall not restrict the continued practice of provider in the contracted HPSA after his/her obligation is completed.

_____ Continuing professional education time and funds shall be made available.

_____ Site shall communicate with the State Medical Education Board staff regarding the status of providers, including resignations, terminations and extended leave of absence.

_____ Site shall document all circumstances surrounding resignations and terminations.

_____ Site must immediately inform the State Medical Education Board if it is no longer willing or able to comply with any of the above conditions.

SECTION III – PRACTICE SITE CERTIFICATION

To be completed by official authorized to warrant the foregoing on behalf of the practice entity.

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation(s) of the information contained may result in the forfeiture of our entity's eligibility to participate in the State Loan Repayment Program

_____ _____

Signature and Title of practice entity official Name of practice entity

Official Notary:
I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, _____(county official), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____ , County of _____and state of _____,

This _____day of _____2006.

_____

Notary Public (Full legal signature)

Affix Seal My commission expires:_____

Mail your completed application to:

State Medical Education Board of Georgia
Georgia Physician Loan Repayment Program
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496

Direct questions to 404/206-5420
E-mail: SMEB@dch.ga.gov
Website: www.SMEB.georgia.gov

Rev.6/06

Physician Applicant Summary Data Sheet

Physician's Full Legal Name: _____

Social Security Number: _____ Physician License Number: _____

Date Available for Practice: _____ Practice Start Date: _____

Practice Name: _____ County Name: _____

Street Address: _____ Telephone: ( ) _____

_____ Zip Code: _____

Ownership of Practice: _____

Type of Practice: *Not-for-profit* ☐ *Public* ☐ *Private* ☐

Estimated total amount of outstanding medical education loan debt: $_____

_____

Attachment Checklist (check all application enclosures):

☐ *Copy of employment contract*

☐ *Practice Site Assessment*

☐ *Lender Disclosure Form/s* (#)

☐ *Copy of original Promissory Note(s) for each loan*

Reference letters/documents regarding:

☐ *Rural Expertise/background*

☐ *Exceptional Clinical Skills*

☐ *Achievements/Accomplishments*

☐ *Previous Dental Practice*

Georgia Physician Loan Repayment Program
Outstanding Physician Education Loan Debt Information
---------LENDER DISCLOSURE--------

Applicant: This form must be sent to each lending institution or agency for which you are seeking loan repayment. The lending institution should forward the completed form to our office.

Lender: If the named individual's application is approved, the information requested below will be used to arrange third party pre-payment of a portion or all of the applicant's debt.

Applicant's Name as it Appears on Loan: _____

Original Lending Institution, Federal or State Program, Please Provide:

Full Name of Institution or Program | Contact Person | Telephone Number

Street Address | City | State | Zip

_____ $_____ _____
Loan ID Number | Original Loan Amount | Date of Original Loan

_____ $_____ _____
Grace Period/Forbearance Dates | Current Balance | Date of Balance

_____% _____
Interest Rate | Simple or Compound

If interest rate is variable, explain terms: _____

Purpose of loan as indicated on original loan application: _____

Certification by Applicant Borrower:

I hereby authorize the government or financial Institution named above to release this information to the State Medical Education Board of Georgia for the purpose of repayment of outstanding medical education debt through the Georgia Physicians Loan Repayment Program.

I also certify the accuracy of the enclosed information and apply to enter into an agreement with the STATE MEDICAL EDUCATION BOARD OF GEORGIA – GEORGIA PHYSICIAN LOAN REPAYMENT PROGRAM of all or the appropriate portion of the education loan listed above, incurred solely for the cost of medical education, including reasonable living expense at a school of medicine or osteopathy.

Full Legal Signature: _____ ***Date***: _____

Certification by Authorized Agency of Lending Institution:

The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state or government educational loan, made for the purpose of meeting the borrower's costs of attaining the degree of Doctor of Medicine or Osteopathy.

_____ _____
Print/Type Name of Authorized Agent | Title

Official Signature: _____

Lender Organization's Federal Employer Identification Number**:**_____

Return to: State Medical Education Board of Georgia, 1718 Peachtree Street, NW, Suite 683, Atlanta, GA 30309-2496

Make Additional copies as Needed

1 Legal Page Document starting next page

STATE MEDICAL EDUCATION BOARD OF GEORGIA
AUTHORIZATION and RELEASE FORM
for the Georgia Physician Loan Repayment Program

FULL LEGAL NAME OF APPLICANT:_____

TO WHOM IT MAY CONCERN:

I, _____, have filed an application with the State Medical Education
Applicant's Full Legal Name

Board of Georgia loan repayment grant to repay the cost of my tuition and other expenses while obtaining my medical education and training. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have entered into a contract with an eligible practice entity, submitted all required application forms and documentation and closed all medical education debts and obligations, are eligible for loan repayment. To this end, and for the entire contract period, I hereby authorize and request any college or school official, lending institution or organization and any other person or official of any firm, association or corporation, including, but not limited to, those persons whose names I have given as personal references on my application, to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may by submitted to them by the State Medical Education Board or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by State Medical Board, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the State Medical Education Board, who shall comply in good faith with this authorization and request from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said State Medical Education Board.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in Sections 38-418, 38-419.1 of the Georgia Code Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this _____day of _____, 2006.

_____
Applicant's Full Legal Signature

STATE OF _____ **COUNTY OF** _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____,

Applicant's Full Legal Name

to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____

and State of _____, this _____day of _____, 2006.

_____
Legal Signature, Notary Public

(Place Seal Imprint Here)

My Commission Expires: _____